Mother's Imprint or Parent/Guardian Information:	*Child's Imprint or Child Information:*
Name and Address (Print):	Name and Address (Print):

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my child's immunizations are due and to keep a central record of my child's immunization history. I understand that I can get a copy of my child's record from my medical provider or local health department.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Parent/Guardian	Date

New Jersey Department of Health and Senior Services
Vaccine Preventable Diseases Program
P.O. Box 369
Trenton, NJ 08625-0369

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

Distribution: Original - Medical Record
Copy - Parents/Guardians

IMM-32
MAR 02